DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G177	A. BUILDING _____ B. WING _____	06/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	249 11TH STREET, SE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 9, 2008 through June 10, 2008. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a population of three males with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and three day program, interviews with clients and staff, and the review of clinical and administrative records including incident reports.	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for one of the two clients included in the sample. (Client #1) The findings include: 1. On June 9, 2008 at 8:39 AM, Client #1 was observed during the evening medication pass being administered Buspar HCL 10 mg, Cogentin 1 mg and Neurontin 300 mg. Interview with the Licensed Practical Nurse (LPN) at approximately	W 124	The facility must inform each client, parent or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. Currentley the process of obtaining a Permanent limited medical guardian has been initated for Client #1. Petition for the appointment of a Permanent Limited Guardian was filed on July 9, 2008 with the Superior Court Of The District of Columbia Probate Division. Client #1 hearing has been set for August 14, 2008 at 11 am. In the future, each individuals parent and/or guardian wil be informed of the individuals medical condition and of the right to refuse treatment. A informedl consent form will be given to be signed and dated by each individual's guardian. Attachment #1	7-9-2008

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVES SIGNATURE — TITLE — (X6) DATE

7/10/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 9:30 AM revealed that client was prescribed these medications for behavioral management. Review of Client #1's current physician's orders confirmed that the client was prescribed the aforementioned medication as well as Zyprexa 7.5 mg. Further interview with the LPN revealed that the medications were incorporated into the client's Behavior Support Plan (BSP) dated May 13, 2008. The BSP addressed the targeted behaviors that included physical aggression, property destruction and non-compliance behaviors. On June 9, 2008 at approximately 11:00 AM, further review of Client #1's record failed to provide evidence that written informed consent had been obtained for the use of the aforementioned medication. Continued review of Client #1's records revealed a Psychological assessment dated May 13, 2008. This assessment documented that the client had profound mental retardation and lacked the capacity to process information effectively to make sound decisions. At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or her right to refuse treatment had been explained to the client and/or legal sanction representative. 2. The facility failed to obtain consents prior to the use of sedation for a medical appointments and/or to notify the clients guardian the risks and benefits of treatments for one of the two clients in the sample. (Client #1) Review of Client #1's physician orders on June 9, 2008 at approximately 11:00 AM revealed the	W 124	Consents prior to the use of sedation for a medical appointments and/or to notify the clients guardian the risks and benefits of treatments must be obtained. Currentley the process of obtaining a Permanent limited medical guardian has been initated for Client #1. Petition for the appointment of a Permanent Limited Guardian was filed with the Superior Court Of The District of Columbia Probate Division on July 9, 2008 Client #1 hearing has been set for August 14, 2008 at 11 am.	7-9-2008

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W 124	Continued From page 2 following sedations for medical procedures: a. On June 10, 2008 and April 11, 2008, the client received Xanax 3 mg prior to a scheduled dental appointments; b. On March 17, 2008, April 10, 2007 and April 17, 2008, the client received Xanax 3 mg prior to a swallowing studies; and c. On April 22, 2008, the client received Xanax 3 mg prior to neurology appointment; d. On January 24, 2008, the client received Xanax 3 mg prior to pain management appointment; e. On November 14, 2007, the client received Xanax 3 mg prior to EKS appointment; and f. On November 15, 2007, the client received Xanax 3 mg prior to EKS appointment Interview with the Qualified Mental Retardation Professional (QMRP) on June 9, 2008 at approximately 3:00 PM revealed that Client #1 had no legal guardian. On June 9, 2008 at 11:00 AM, further review of Client #1's record failed to provide evidence that written informed consent had been obtained for the use of the aforementioned medications. Continued review of Client #1's records revealed a Psychological assessment dated May 13, 2008, indicated that the client's cognitive abilities tested in the profound range of retardation and he lacked the capacity to process information effectively to make sound decisions.	W 124	Currentley the process of obtaining a Permanent limited medical guardian has been initated for Client #1. Petition for the appointment of a Permanent Limited Guardian was filed on July 9, 2008 with the Superior Court Of The District of Columbia Probate Division Client #1 hearing has been set for August 14, 2008 at 11 am. Attachment #1	7-9-2008

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W 124	Continued From page 3 At the time of the survey, the facility failed to provide evidence that the potential risks involved in using this medication, or his right to refuse treatment had been explained to the client and/or legal sanction representative. [See W263] Interview with the Qualified Mental Retardation Professional (QMRP) on June 9, 2008 at approximately 11:00 AM revealed that Client #1 did not have a court appointed guardian. Review of the client's Psychological assessment dated May 13, 2008, at revealed that the client did not have the ability to make decisions on his behalf regarding habilitation planning, residential placement, finances, treatment and medical matters.	W 124		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide receipts for withdrawals from the clients personal funds account for one of the two clients in the sample. (Client #1) The finding includes: The financial record review was conducted on June 9, 2008 for Client #1. Interview with the Qualified Mental Retardation Professional revealed that the client received $70.00 Supplemental Security Income (SSI) monthly. The review of the bank statements from July 2007 through May 2008 revealed a withdrawal on	W 140	On July 23rd, 2007, client number one's mother requested $50 to be used for recreational activities with her son. [redacted] signed a letter confirming that she received $50 on July 23rd, 2007 per her request however she did not provide receipts. In the future, receipts for money withdrawn from individuals accounts will be provided. Attachment #2	6-16-2008

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W 140	Continued From page 4 July 23, 2007 in the amount of $50.00. There were no receipts to determine how or when the monies were spent.	W 140		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse were immediately reported to the administrator and other officials according to District Law (22 DCMR, Chapter 35, Section 3519.10) one of the two clients included in the sample. (Client #2) The finding includes: Review of the facility's incident and investigative reports on June 9, 2008 at 8:35 AM revealed that on August 23, 2007, the day program contacted the facility to report that the client arrived with a scratch on his forehead. The facility's nurse evaluated the client on August 24 and observed that the client had a swollen lip and his neck was hurting. The client was transported to the emergency room. The incident report indicated that the client spoke with his mother and told her that a staff hit him on his lip. Although the incident was reported to the facility's administrator and subsequently investigated, the allegation of abuse was not reported to the State agency as required by local regulations.	W 153	The facility's investigation was completed on August 27th, 2007. The current Incident Mangement Coordinator reviewed, signed and dated the aforementioned investigation. However, in the future investigations will be signed by the Incident Management Cooridinator within the five allotted days. Attachment #3	7-10-2008

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W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure required investigations were reviewed by the administrator or designee within five working days, for one of the two clients (Client #2) included in the sample. The finding includes: Review of the facility's incident and investigative reports on June 9, 2008 at 8:35 AM revealed that on August 23, 2007, the day program contacted the facility to report that the client arrived with a scratch on his forehead. The facility's nurse evaluated the client on August 24, 2007 and observed that the client had a swollen lip and his neck was hurting. The client was transported to the emergency room. The incident report indicated that the client spoke with his mother and told her that a staff hit him on his lip. Although the investigation was not substantiated, the above outcome was not reported to the administrator within the five allotted days. At the time of the survey, the facility failed to provide evidence that the administrator or designee reviewed the results of all investigations within five working days of the incident.	W 156	In the future all investigations will be signed by the administrator and the Incident Management Coordinator. The current Incident Management Coordinator has reviewed the August 23rd, 2007 incident and has signed the aforementioned investigation. Attachment # 3	7-10-2008
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and	W 194		

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W 194	Continued From page 6 techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to demonstrate the skills and techniques necessary to implement clients feeding protocol as written one of the two clients in the sample. The finding includes: On June 9, 2008 at 7:40 AM, Client #1 was observed having breakfast. His meal consisted of a chopped texture. He drank his beverages out of a regular cup. At 8:00 AM, Client #1 was observed drinking boost powder with milk using a regular cup. During the medication administration at 8:39 AM, Client #1 was observed drinking his water to consume his medication out of a regular cup. At 4:20 PM, Client #1 was having a snack of berry yogurt and lemonade drink. The client drank from a sipper cup (a cup with a straw). During the dinner observation, Client #1 was observed drinking several beverages. The client was observed drinking water from a sipper cup, carnation instant breakfast mix and lemonade beverage were from a regular cup. On June 10, 2008 at 11:00 AM, the client was observed drinking from a sipper type cup with spillage. No staff were present at that time. Interview with the direct care staff and House Manager on June 9, 2008 at approximately 6:45 PM indicated that the client should receive his liquids through a sipper type cup. Review of the client's physician orders on June 10, 2008 at	W 194	Staff was inserviced on Client #1 diet and feeding protocol on 6-16-2008. In the future, staff will have the skill and techniques necessary to implement Client #1 feeding protocol. Attachment #4	6-16-2008

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W 194	Continued From page 7 10:30 AM revealed that Client #1, "serve all liquids in sipper cup to drink a little at a time". Further review of the client's medical record revealed a Speech Language consultation note dated April 19, 2008. According to the consultation note it was recommended that the client was at risk for aspiration. There was no evidence that the staff followed Client #1's physician orders for using the sipper cup.	W 194		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to ensure Client #2's self-medication program was implemented as written. The finding includes: 1. On June 9, 2008 at 8:20 AM Client #2 was observed receiving his medication. The client came to the medication area with his cup of water. The nurse prompted him to state the name of his medications, which he did. Review of the client's record revealed that his self medication program calls for the client to state the name and dosage of the medication. At the time of the observation, the client was not prompted to	W 249	Designated nurse was re-trained by the Director of Nursing on proper implementation and documentation of Client # 2 self medication program. Attachment # 5	7-9-2008

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W 249	Continued From page 8 state the dosage of the medication. The nurse was interviewed and he acknowledged that the program was not implemented as written. 2. The QMRP failed to ensure self-medication skills obtained at the group home was re-enforced at his day program. Client #2 was observed receiving his medication at his day program on June 9, 2008 at 12:00 PM. The nurse punched the medication into a cup and handed the cup to the client. The client took the cup and ingested the medication. The nurse poured the water and handed the cup to the client and the client drank the water. Review of the clients self-medication assessment dated March 15, 2008 revealed the client was capable of learning the name and dosage of his psychotropic medications with verbal assistance from the medication nurse. At the time of the medication administration observation, the nurse did not prompt the client to say the name and dosage of his medication. Interview with the nurse revealed that he knows the name of his medication and that he was capable of punching the medication if given the opportunity. Interview with the QMRP acknowledged that the day program was not giving the client an opportunity to maintain his self medication skills.	W 249	A copy of Client #1 self med assesment was provided to his day placement on7-8-2008. In the future, the QMRP will ensure self medication skills/ programing is reenforced at the individuals Day Program during monitoring visits. Attachment # 6	7-8-2008
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan.	W 255		

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W 255	Continued From page 9 This STANDARD is not met as evidenced by: Based on record review, the Qualified Mental Retardation Professional (QMRP) failed to review and revise the individual Program Plan (IPP) once the client has successfully completed an objective identified in the IPP for one of the two clients in the sample. (Client #1) The finding includes: Review of Client #1's IPP dated May 19, 2008 revealed a program objective which stated, "[the client] will make a purchase with verbal prompts from staff on 8/10 consecutive trials in three consecutive months." Review of the previous IPP dated June 2007 and the Qualifed Mental Retardation Professional (QMRP)monthly notes revealed the client had met this objective since arch 2008. Additionally, review of the QMRP quarterly review notes dated December 16, 2007 indicated that the client achieved the program objective with 100% independence since February 2008.	W 255	Client #1 IPP has been revised by the QMRP. In the future, the QMRP monitor weekly and will revise those programs once critera has been met. Attachment # 7	7-10-2008
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of	W 263		

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W 263	Continued From page 10 the client, parents (if the client is a minor) or legal guardian for one of the two clients in the sample. (Client #1) The finding includes: The facility failed to obtain informed consent prior to the use of restrictive measures as described in Client #1's Behavior Support Plan and sedation. [See W124, 1]	W 263	Currentley the process of obtaining a Permanent limited medical guardian has been initated for Client #1. Petition for the appointment of a Permanent Limited Guardian was filed with the Superior Court Of The District of Columbia Probate Division on July 9, 2008 Client #1 hearing has been set for August 14, 2008 at 11 am.	7-9-2008
W 440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to hold evacuation drills at least quarterly for each shift of personnel. The finding includes: Interview with the Qualified Mental Retardation Professional and review of the staff pattern on June 9, 2008 at 2:00 PM revealed the following schedule staffing pattern: Monday - Friday 7:00 AM - 3:00 PM; 3:00 PM -11:00 PM; and 11:00 AM -7:00 AM. Saturday - Sunday 7:00 AM - 11:00 PM; and 11:00 PM - 7:00 AM Review of the fire drill log revealed that the facility failed to hold fire evacuation drills for all shifts at	W 440	Attachment #1 Staff were retrained on RCM of Washington, Inc. fire drill policy on 6-16-2008 by the facilty House Manager. In the future, fire drills will be conducted in accordance with regulation. Attachment #8	6-16-2008

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I 000	INITIAL COMMENTS A licensure survey was conducted from June 9, 2008 through June 10, 2008. A random sample of two residents was selected from a population of three males with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and three day program, interviews with residents and staff, and the review of clinical and administrative records including incident reports.	I 000		
I 065	3502.13 MEAL SERVICE / DINING AREAS Each GHMRP shall train the staff in the use of proper feeding techniques and monitor their appropriate use to assist residents who require special feeding procedures or utensils. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the GHMRP failed to train staff in the use of proper feeding procedures for one of the two residents in the sample. (Residents #1) The finding includes: On June 9, 2008 at 7:40 AM, Resident #1 was observed having breakfast. His meal consisted of a chopped texture. He drank his beverages out of a regular cup. At 8:00 AM, Resident #1 was observed drinking boost powder with milk using a regular cup. During the medication administration at 8:39 AM, Resident #1 was observed drinking his water to consume his medication out of a regular cup. At 4:20 PM, Resident #1 was having a snack of berry yogurt and lemonade drink. The resident drank from a	I 065	See W 194	6-16-2008

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	HFD03-0175	A. BUILDING _____ B. WING _____	06/10/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
R C M OF WASHINGTON	249 11TH STREET, SE WASHINGTON, DC 20019

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I 055	Continued From page 1 sipper cup (a cup with a straw). During the dinner observation, Resident #1 was observed drinking several beverages. The resident was observed drinking water from a sipper cup, carnation instant breakfast mix and lemonade beverage were from a regular cup. On June 10, 2008 at 11:00 AM, the resident was observed drinking from a sipper type cup with spillage. No staff were present at that time. Interview with the direct care staff and House Manager on June 9, 2008 at approximately 8:45 PM indicated that the resident should receive his liquids through a sipper type cup. Review of the resident's physician orders on June 10, 2008 at 10:30 AM revealed that Resident #1, "serve all liquids in sipper cup to drink a little at a time". Further review of the resident's medical record revealed a Speech Language consultation note dated April 19, 2008. According to the consultation note it was recommended that the resident was at risk for aspiration. There was no evidence that the staff followed Resident #1's physician orders for using the sipper cup.	I 055	See w194	6-16-2008
I 135	3605.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that each shift conducted a fire drill four times a year. The finding includes: Interview with the Qualified Mental Retardation	I 135	See w440	6-16-2008

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I 135	Continued From page 2 Professional and review of the staff pattern on June 9, 2008 at 2:00 PM revealed the following schedule staffing pattern: Monday - Friday 7:00 AM - 3:00 PM; 3:00 PM -11:00 PM; and 11:00 AM -7:00 AM. Saturday - Sunday 7:00 AM - 11:00 PM; and 11:00 PM - 7:00 AM Review of the fire drill log revealed that the facility failed to hold fire evacuation drills for all shifts at least quarterly. These above findings were referred to the Office of the Fire Marshall.	I 135		
I 189	3508.7 ADMINISTRATIVE SUPPORT Each GHMRP shall maintain records of residents ' funds received and disbursed. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to maintained each resident's funds received and disbursed for one of the two residents in the sample. (Resident #1) The findings include: The financial record review was conducted on June 9, 2008 for Resident #1. The review of the bank statements from July 2007 through May 2008 revealed a withdrawal on July 23, 2007 in the amount of $50.00. There were no receipts to determine how or when the monies were spent.	I 189	See W140	6-16-2008

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I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to achieve compliance with State regulations pertaining to health (22 DCMR Chapter 35, Section 3509.6). The finding includes: The State regulatory agency conducted a review of personnel records on June 9, 2008, at which time there was no evidence that two direct care staff (Staff #1 and #2), Behavior Specialist, Social Worker, Nutritionist, Podiatrist and Speech Pathologist had current health certificate.	I 206	Client #1 and #2, Behavior Specialist, Social Worker, Nutritionist current health certificate is attached and current. See attachment# 10	7-10-2008
I 225	3510.5(b) STAFF TRAINING Each training program shall include, but not be limited to, the following: (b) Human development through the life cycle (birth to death); This Statute is not met as evidenced by: Based on record review, the GHMRP failed to ensure effective training was provide to each staff.	I 225	Staff were retrained on human development on 6-16-2008 by the Assistant Program Director.	6-16-2008

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I 225	Continued From page 4 The finding includes: Review of the training records on June 10, 2008 revealed that the GHMRP failed to provide training in Human Development.	I 225		
I 229	3510.5(f) STAFF TRAINING Each training program shall include, but not be limited to, the following: (f) Specialty areas related to the GHMRP and the residents to be served including, but not limited to, behavior management, sexuality, nutrition, recreation, total communications, and assistive technologies; This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to document effective training on nutrition areas related to resident safety and appropriate mealtime assistance for one of the two residents in the sample. (Resident #1) The findings include: On June 9, 2008 at 7:40 AM, Resident #1 was observed having breakfast. His meal consisted of a chopped texture. He drank his beverages out of a regular cup. At 8:00 AM, Resident #1 was observed drinking boost powder with milk using a regular cup. During the medication administration at 8:39 AM, Resident #1 was observed drinking his water to consume his medication out of a regular cup. At 4:20 PM, Resident #1 was having a snack of berry yogurt and lemonade drink. The resident drank from a sipper cup (a cup with a straw). During the dinner observation, Resident #1 was observed drinking	I 229	See W194 See W194	6-16-2008 6-16-2008

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I 229	Continued From page 6 several beverages. The resident was observed drinking water from a sipper cup, carnation instant breakfast mix and lemonade beverage were from a regular cup. On June 10, 2008 at 11:00 AM, the resident was observed drinking from a sipper type cup with spillage. No staff were present at that time. Interview with the direct care staff and House Manager on June 9, 2008 at approximately 6:45 PM indicated that the resident should receive his liquids through a sipper type cup. Review of the resident's physician orders on June 10, 2008 at 10:30 AM revealed that Resident #1, "serve all liquids in sipper cup to drink a little at a time". Further review of the resident's medical record revealed a Speech Language consultation note dated April 19, 2008. According to the consultation note it was recommended that the resident was at risk for aspiration. There was no evidence that the staff followed Resident #1's physician orders for using the sipper cup.	I 229	See W194	6-16-2008
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.6, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on record review, the Governing Body	I 379		

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I 379	Continued From page 6 failed to ensure its Incident Management System Policy and Procedures were followed with regards to incident reporting services of law endofmmet or emergency personnel by a staff for one of the two residents in the sample. (Resident #2) The finding includes: Review of the facility's incident and investigative reports on June 9, 2008 at 8:35 AM revealed that on August 23, 2007, the day program contacted the facility to report that the Resident #2 arrived with a scratch on his forehead. The facility's nurse evaluated the client on August 24, 2008 and observed that the resident had a swollen lip and his neck was hurting. The resident was transported to the emergency room. The incident report indicated that the residenet spoke with his mother and told her that a staff hit him on his lip. This incident was not reported to the state agency as required.	I 379	SEE W 153 and 156	7-10-2008
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s individual Habilitation Plan. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure habilitation, training and assistance was provided to residents in accordance with their Individual Habilitation Plan (IHP), for one of the two residents included in the sample. (Resident #2) The findings include: On June 9, 2008 at 8:20 AM, Resident #2 was	I 422		

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I 422	Continued From page 7 observed receiving his medication. The resident came to the medication area with his cup of water. The nurse prompted him to state the name of his medications, which he did. Review of the client's record revealed that his self medication program calls for the resident to state the name and dosage of the medication. At the time of the observation, the resident was not prompted to state the dosage of the medication. The nurse was interviewed and he acknowledged that the program was not implemented as written.	I 422	See W 249	7-8-2008
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Based on observations, staff interviews and record review, the Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the client has successfully completed an objective identified in the IPP for one of the two residents in the sample. (Resident #1) The findings include: Review of Resident #1's IPP dated May 19, 2008 revealed a program objective which stated, "[the resident] will make a purchase with verbal prompts from staff on 8/10 consecutive trials in three consecutive months." Review of the previous IPP dated June 2007 and the Qualifed Mental Retardation Professional (QMRP)monthly	I 424	See W 255	7-10-2008

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I 424	Continued From page 8 notes revealed the resident had met this objective since March 2008. Additionally, review of the QMRP quarterly review notes dated December 16, 2007 indicated that the client achieved the program objective with 100% independence since February 2008.	I 424		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the protections of each resident rights for one of the two residents included in the sample. (Resident #1) The findings include: 1. The facility failed to establish a system that would ensure residents that were informed of their risks and benefits of their medication for one of the two residents in the sample. [See Federal Deficiency Report Citation W124] 2. The facility failed to ensure that each resident's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the resident, parents (if the client is a minor) or legal guardian for one of the two residents in the sample. [See Federal Deficiency Report Citation W263]	I 500	See W 124 See W263	7-9-2008 7-9-2008